AN ANALYSIS OF THE AMERICAN HOSPITAL ASSOCIATION'S PROPOSAL TO MODIFY MEDICARE HOSPITAL REIMBURSEMENT

June 1982

Prepared by the Staff of the
Human Resources and Community Development Division
Congressional Budget Office

This analysis was prepared by the staff of the Human Resources and Community Development Division of the Congressional Budget Office, under the supervision of Nancy M. Gordon (226-2669) and Paul Ginsburg (226-2653). Questions regarding the analysis may be addressed to Lisa Potetz (226-2663).

J932-62

The American Hospital Association (AHA) has proposed a prospective, fixed-price system of reimbursement by Medicare for inpatient hospital services.[1] Under this proposal, Medicare outlays would decrease by about $320 million in fiscal year 1983, and $1.1 billion in 1984. These savings would be reduced by successful appeals and by shifts of some costs to outpatient departments, but the extent of these reductions cannot be estimated. The proposal could be modified to yield even greater savings, however. Savings might increase in 1985 and later years, although some of the provisions applicable after 1984 are too vague to permit a cost estimate.

THE PROPOSAL

Reimbursement rates under the proposal would be set in the following way. Each hospital's most recently reported cost per discharge, excluding payments for return on equity and any adjustments made under Section 223 routine cost limits, and inflated to fiscal year 1983 levels, would be the base payment. An 8.0 percent adjustment would be made to reflect increased hospital input prices in 1983. Beginning in fiscal year 1984, a private organi-

---

1. The AHA proposal has been revised and clarified a number of times since its release on April 14, 1982. This analysis is based upon the most recent draft language available at this time, the version dated June 4, 1982.

zation would determine an annual adjustment factor that would reflect hospital input price increases, plus one percentage point per year to reflect medical technology advances. The organization would be required to use the methodology currently used by the Health Care Financing Administration in constructing the National Hospital Input Price Index.

A further adjustment would also be made to allow reimbursement for capital costs from new projects. This would differ from current policy only in that capital costs associated with projects not approved by a state regulatory agency or required by a facility standards agency would be disallowed.

Each year, small rural hospitals would have the option of receiving payment under the current system or choosing to participate in the prospective system. The current Section 223 limits on routine costs would be maintained for hospitals choosing not to receive prospective payment.

Participating hospitals would choose whether to accept the Medicare rate as payment in full. Those not doing so would be able to charge beneficiaries the difference between actual charges and the Medicare payment, up to a limit that would be set at the

lesser of $1,000 or the hospital's average percentage of charges not paid by Medicare in the base year. The latter limit would preserve the current Medicare discount of roughly 20 percent of charges incurred by beneficiaries.

A number of provisions would encourage hospitals to accept assignment--that is, to accept Medicare reimbursement as payment in full. Investor-owned hospitals would receive return-on-equity reimbursement only if they agreed to accept assignment. Nonprofit hospitals would receive a capital maintenance adjustment similar to the current return-on-equity only if they chose to accept assignment. Hospitals with relatively heavy Medicare and Medicaid patient loads--defined as generating over 50 percent of revenue--would also receive an additional reimbursement increase for choosing to accept assignment. Only hospitals accepting assignment would be reimbursed for bad debts not collected from beneficiaries.

Hospitals would be allowed to appeal their prospective rate on a number of grounds. These include changes in the mix of patients they serve, an increase in the number of beds, and inadequate capital reimbursement. The Provider Reimbursement Review Board would face several time constraints--requests for additional

information from the hospital could be made only within 15 days after the appeal was filed, and if no decision was reached within 90 days, the decision would favor the hospital.

Although only inpatient hospital services are covered under the proposal, it does require that the Secretary of Health and Human Services submit a proposal for prospective payment of outpatient and emergency services early in the 98th Congress. No enactment date is proposed, however.

The Secretary of Health and Human Services (HHS) would be required to ensure that growth in aggregate Medicare admissions be held to 2 percent in fiscal year 1983. The mechanism with which to accomplish this outcome is not specified other than that it be utilization review. Payments to hospitals could not be reduced by this requirement except for reasons of the medical appropriateness of particular admissions.

Preadmission screening to determine the necessity of all Medicare admissions would be required under the proposal. The necessity of emergency admissions would be assessed within 48 hours of admission. Hospitals with approved utilization review programs would be reimbursed for the costs of this review. Other hospitals

would have admissions reviewed by agencies approved by the Department, presumably fiscal intermediaries or Professional Standards Review Organizations.

After two years, the AHA proposal would allow hospitals in an area to elect a competitive process in which each hospital would propose a Medicare reimbursement rate, which would be reviewed for approval by Medicare. If a bid was not approved or negotiated, the hospital would receive the average of the area's approved reimbursement rates.

EFFECTS OF THE AHA PROPOSAL ON FEDERAL SPENDING

The AHA proposal would reduce Medicare outlays by $320 million in fiscal year 1983, and $1.1 billion in fiscal year 1984. (see Table 1). If the proposal described for 1983 and 1984 was maintained, savings would increase in the out-years. Because the competitive bidding process intended for 1985 is not clearly specified and has incentives that could lead to higher payments, out-year savings might not be achieved. Since the 1981 reconciliation act awarded states flexibility in making hospital payments under Medicaid, no Medicaid reimbursement changes are assumed by this proposal.[2]

---

2. In the past, Medicaid savings would have resulted from changes in Medicare hospital reimbursement. This estimate (Continued)

TABLE 1. BUDGETARY EFFECTS OF VARIOUS PROVISIONS OF THE AHA PROPOSAL,[a] FISCAL YEARS 1983 AND 1984 (In millions of dollars)

	1983 Outlays	1984 Outlays
Prospective Baseline	31,060	35,920
Nonparticipating Hospitals[b]	1,300	1,520
Adjustments to the Rate Base:		
Section 223	270	60
Elimination of return-on-equity	-310	---
Adjustments to the Prospective Rate:		
Price adjustment[c]	2,480	3,020
Admissions growth	1,060	1,190
Intensity factor	---	360
Capital costs pass-through[d]	360	410
Utilization review[e]	---	---
Capital maintenance factor[f]	700	---
Return-on-equity	230	---
Volume adjustment[g]	70	10
Bad debts[h]	---	---
Increase for Nonparticipating Hospitals	220	240
Total	37,440	42,730
Current Policy	37,760	43,840
Difference	-320	-1,110
Percentage Increase from Previous Year:		
Current Policy	16.7	16.1
AHA Proposal	15.7	14.1

(Continued)

TABLE 1. (Continued)

Footnotes.

a. June 4, 1982, version.

b. Of small rural hospitals, which account for about 8 percent of reimbursement, 50 percent are assumed to choose to participate in the prospective system.

c. CBO forecasts an 8.4 percent increase in hospital input prices for fiscal year 1984.

d. HCFA has estimated reimbursements for capital costs to be 7 percent of Medicare payments.

e. The current policy base includes payments for hospital-based utilization review. No increase in payments is assumed under the proposal's utilization review program.

f. The AHA estimates a $24 billion equity base for community hospitals in 1980, up 10 percent from 1979. If the increase has been 10 percent a year, the base would be about $30.7 billion in 1983 for participating hospitals. The rate is the GNP deflator, which the CBO estimates is 7.3 percent in 1983 and 6.6 percent in 1984.

g. The AHA estimates that 16.8 percent of payments are made to hospitals with a Medicare and Medicaid patient load between 50 and 65 percent, and 3.8 percent with a patient load over 65 percent. Under the proposal, the former hospitals would receive a 1 percent increase in their base, and the latter would receive a 1.5 percent increase. All these hospitals are assumed to participate in the prospective system and to accept assignment.

h. Only hospitals accepting assignment would be reimbursed for bad debts under the proposal. The estimate assumes that most hospitals with significant bad debts under Medicare would choose to accept assignment, and therefore there would be virtually no change in bad debt payments from current policy.

These savings would be reduced by two factors that are difficult to quantify. First, savings could be offset if hospitals shifted costs to outpatient services, which would continue to be reimbursed on a cost basis under the proposal. In addition, if laboratory or radiology services were shifted from Part A to Part B payment--by leasing, for example--the hospital's Part B reimbursement would increase while the prospective base would not be lowered.

Second, the savings estimate does not include the effects of appeals. There is no way to estimate the extent to which savings would be reduced by appeals, but it could be significant given the broad grounds allowed and the fact that hospitals choosing to appeal would not risk receiving a lower rate. Each 1 percent increase in reimbursements resulting from these two factors would reduce 1983 federal savings by about $360 million, and savings in subsequent years by more.

---

1. (Continued)
assumes that because states no longer have to use Medicare reimbursement as a basis for Medicaid payments, no savings from reduced hospital reimbursement by Medicaid need to be included. This assumption is currently being reconsidered in light of actual state responses to the new Medicaid provision.

Assumptions

The estimate makes a number of assumptions as to how hospitals would respond to the proposed payment system. These involve the number of hospitals participating, the number of participating hospitals that would accept assignment, and the effect of the proposal on Medicare admissions.

Participation. Fifty percent of small rural hospitals are assumed to choose participation in the prospective system. The average rate of increase in Medicare costs for these hospitals is slightly lower than the average, so those with relatively low growth rates would benefit from a prospective rate based on the higher overall growth rate. Those hospitals with relatively high rates of growth would benefit from remaining in the current reimbursement system.

Assignment. Hospitals accounting for 90 percent of reimbursement to nonprofit hospitals and 75 percent of reimbursement to investor-owned hospitals are assumed to accept assignment, although the proportion would decline in later years. Most hospitals would find the payment incentives attractive, while the benefits of billing beneficiaries for unpaid charges would be limited by the requirements for preservation of the Medicare discount, the

costs of collection and bad-debt risks, and the potential competition from other hospitals in the area choosing to accept assignment. Hospitals choosing not to accept assignment would be those with a relatively small Medicare patient load, or located in an area without other hospitals, or to whom the bad-debt risks appear minimal. A lower rate of assignment is assumed for investor-owned hospitals because they more often tend to locate in areas in which beneficiaries would be able to pay higher out-of-pocket costs. In later years, if the program described for the first years was continued, more hospitals might opt not to accept assignment because the payment incentives would diminish as a share of the prospective rate.

The savings estimate is sensitive to the assignment rate assumption. For example, if assignment is assumed for 75 percent of nonprofit and 50 percent of investor-owned hospitals, as in the AHA's estimate of the proposal's effects, outlays under the proposal would be reduced by about $190 million in fiscal year 1983.[3]

---

3. American Hospital Association, "American Hospital Association Proposal: Medicare Prospective Fixed Price Payment to Hospitals" (approved by the Executive Committee of the Board of Trustees, American Hospital Association, April 14, 1982).

Admissions. The CBO estimate assumes that hospitals would respond to the proposal's implicit incentive to increase admissions. Because payment would be a fixed rate per case, hospitals would have an incentive to increase revenues by increasing the number of Medicare admissions, particularly beneficiaries whose care would cost less than the average. In general, the costs of treating an additional patient would be less than the prospective payment, which would be based on average costs. Furthermore, hospitals might seek patients with less costly diagnoses--possibly patients who would not otherwise have been hospitalized--in order to maximize the number of admissions where there would be a large differential between the reimbursement rate and the cost of treatment.

Although the proposal requires that the Secretary of Health and Human Services limit the growth in Medicare admissions to 2 percent in 1983, this target--which is about 1 percentage point below the increase projected under current policy--is not likely to be met. Experience with utilization review is not encouraging enough to expect that it could completely counterbalance the proposal's powerful incentive for increased admissions. It is particularly doubtful that review performed by the hospital, as specified under the proposal, would be effective enough to meet the

1983 goal, given the hospital's financial interest in having admissions approved. Without utilization review, however, the increase in admissions under the proposal would be even greater.

While the mandate to the Secretary of HHS might ultimately improve the effectiveness of utilization review, achieving the 1983 goal would be very difficult. Many hospitals have experience performing utilization review under the PSRO program, so initially they are likely to be able to demonstrate to the Secretary that they have the capability to perform effective utilization review. If the efforts of these hospitals (and other organizations where the hospital does not conduct review) should fall short of the limit, recognition of the shortfall by HHS would come too late in fiscal year 1983 to make achieving the goal for that year possible.

POTENTIAL EFFECTS OF THE AHA PROPOSAL ON TOTAL HOSPITAL COSTS

A prospective fixed-rate system of hospital payment would offer more incentives for increased efficiency and lower costs than the current system. A prospective system would allow hospitals to keep the difference between the predetermined reimbursement rate and the cost of providing services to the Medicare beneficiary.

This is in contrast to proposals that would set a ceiling on growth in a hospital's Medicare costs, which do not encourage hospitals to reduce growth in costs below the ceiling.

Other incentives present in the AHA proposal would limit its cost-reducing effects, however. Pressure to contain costs would be reduced by the opportunities mentioned earlier to shift costs to outpatient services and increase admissions of less costly cases.

Increasing charges to non-Medicare payers would also lessen pressure to reduce costs. While some cost shifting would occur, the proportion of reimbursement reductions shifted to other payers is difficult to predict. Medicare and Medicaid beneficiaries, on average, generate 45 percent of gross hospital revenue in community hospitals, so that, despite the incentive to shift costs, many hospitals with a relatively high proportion of Medicare cases would find it difficult to do so. Moreover, commercial insurers, to whom costs would be shifted, might take actions to make cost-shifting more difficult--for example, by developing preferred provider plans (PPOs), although they could probably not do so very rapidly.

Allowing hospitals to make additional charges to beneficiaries might also reduce the extent of cost containment achieved, despite its potential to increase competition among hospitals. The ability to make charges to patients would reduce the need for hospitals to keep within the prospective payment rate by reducing costs.

Finally, the competitive system provided for in later years under the AHA proposal would be difficult to administer, and some of its specific provisions would limit the likelihood of cost-reducing effects. A hospital's proposed reimbursement rate would have to be considered in terms of the type of services it would provide to Medicare beneficiaries, requiring an assessment of the hospital's case mix. For example, the services purchased from a teaching hospital providing open heart surgery would be different from those purchased from a smaller facility, and the rates would have to differentiate between them. Furthermore, because hospitals that did not submit bids, or whose bids were not approved, would receive the average of accepted bids in the area, there would be no incentive for hospitals to bid low. Limiting beneficiary access to successful bidders, which is not called for in the proposal, might be necessary in order to elicit lower bids from hospitals.

EFFECTS ON BENEFICIARIES

The AHA proposal would probably not have much impact on beneficiaries initially, but they could face higher out-of-pocket costs and reduced access to care in later years. Although the proposal would allow hospitals to bill beneficiaries for the difference, several factors would probably lead most hospitals to accept assignment in the early years of the proposal: potential competition from other hospitals that did not refuse to accept assignment; local political concern; and the favorable reimbursement treatment offered under the proposal.

If the program were continued in later years, hospitals might be less inclined to accept assignment. First, the incentives to do so--adjustments for return-on-equity and capital maintenance--would become smaller relative to the difference between charges and the share of the prospective rate over time. Second, Medicare beneficiaries might increase their supplemental coverage to protect themselves from higher out-of-pocket hospital costs, reducing competitive pressures to avoid such charges. The competitive bidding program outlined for later years would affect the assignment rate, but the effects are difficult to determine because the program is not clearly specified.

While, in theory, beneficiaries could avoid the extra charges by choosing hospitals that accept assignment, in some cases their choice might be determined by where their physician practices or by emergency. Further, hospitals without nearby competitors would be more likely to charge beneficiaries.

Beneficiaries treated in hospitals that did not accept assignment could find their liabilities increased significantly. The $1,000 maximum charge per hospital stay would be burdensome to the average beneficiary. Although some beneficiaries would have supplemental insurance coverage that might pay these extra charges, even they would ultimately pay the charges through higher insurance premiums.

Beneficiary liability would be limited to some degree by the requirement of preserving the Medicare discount. That is, beneficiaries could not be required to pay a differential that would lead to a total payment to the hospital greater than the proportion of charges that would have been paid by Medicare if the current reimbursement system had been maintained. On the other hand, the requirement that the discount be preserved gives hospitals not accepting assignment an incentive to increase charges more rapidly than they otherwise would.

Like other proposals to reduce Medicare payments to hospitals without affecting rates charged to other payers, the AHA proposal might, in the long run, reduce access to hospital services by Medicare beneficiaries. First, some persons would not be able to afford to use hospitals that did not accept Medicare assignment. This in turn could pose problems in beneficiaries' access to physician services, because choice of hospital depends on where physicians have privileges. Second, hospitals with a high proportion of Medicare patients could have financial problems if prospective rates grew more slowly than their costs. If these hospitals were forced to close or reduce their Medicare patient load, access by beneficiaries would be further reduced.

EFFECTS ON OTHER PAYERS

All payers for hospital services stand to benefit from any reductions in costs that occurred in response to prospective reimbursement under Medicare, but commercial insurers could find their competitive position vis-a-vis Blue Cross plans weakened. To the extent that hospitals would pass costs on to other payers, commercial insurers would pay more for hospital care since their plans pay on the basis of hospital charges. Blue Cross plans in many states, in contrast, use a cost-based system similar to that of Medicare. In 1980, the share of charges ultimately reimbursed was

80 percent for Medicare, 86.5 percent for Blue Cross and 92 percent for commercial insurers. Any additional cost shifting would exacerbate this differential.

A prospective system such as the one proposed would lead to less cost shifting than other policies to reduce Medicare costs, however. Because the hospital could keep the difference between the prospective rate and the costs incurred, it would have an incentive to reduce costs rather than shift them. Other methods that would reduce Medicare payments would encourage hospitals to pass costs on.

POSSIBLE VARIATIONS ON THE PROPOSAL

Several changes in specific provisions of the AHA proposal could result in greater savings, or remove some of the proposal's shortcomings. These would:

- Restructure adjustments to the base;
- Reduce incentives for increased admissions;
- Make assignment mandatory.

Restructure Adjustments to the Base

Two changes in calculating the base payment would increase savings and improve incentives for efficiency. First, including savings from Section 223 limits on routine costs in the base would

reduce outlays under the proposal by about $300 million in fiscal year 1983. Furthermore, because the limits affect only the most costly hospitals, retaining the penalty in the base price would lessen the tendency of the proposal to reward the highest-cost hospitals the most.

A second adjustment would remove capital costs from the base, which are reimbursed twice under the proposal. Because capital costs are included in the base, the annual inflation adjustment increases reimbursement for them. But the proposal allows an additional passthrough for all capital costs associated with approved projects. Excluding capital costs from the base would avoid this double payment. This would save about $250 million in fiscal year 1983, and $610 million in 1984.

Reduce Incentives for Increased Admissions

Rather than relying solely on utilization review to counter the incentives for increased admissions, the proposal could be revised to include other features to reduce its incentive for increasing admissions and favoring less costly cases. Hospitals could receive reduced payments for admissions beyond a set rate of increase from the previous year's level. For example, admissions beyond 2 percent could be given less weight in determining the

hospital's final reimbursement. The reduction could be scaled so that hospitals closer to the predetermined rate would be penalized less than those with very high growth rates.

In addition, the hospital's case mix could be compared to that in its base year, with adjustments made to reflect changes in costliness. Almost all hospitals have diagnostic coding systems that would make use of a simple case mix index feasible at this time. If admissions under both these options were held to their projected increases under current policy, outlays under the proposal would be reduced by $95 million in fiscal year 1983, and by greater amounts in the out-years.

Make Assignment Mandatory

Mandatory assignment would prevent the increased beneficiary liability possible under the proposal, and therefore reduce the threat of reduced access to hospital services by Medicare beneficiaries.

In addition, mandatory assignment could increase the cost containment induced by the proposal, as discussed above; and could also increase budget savings in two ways. First, voluntary assignment could direct patients toward more costly hospitals. To

the extent that high-cost hospitals chose to accept assignment, patients would be encouraged to use them instead of low-cost hospitals that made extra charges. Second, mandatory assignment could defer some costly provisions designed to make assignment attractive to hospitals, such as capital maintenance allowances.